STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155747	A. BUILDING 00 B. WING	07/22/2011

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WOODCREST NURSING CENTER	1300 MERCER AVE DECATUR, IN46733

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F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: July 18, 19, 20, 21, and 22, 2011 Facility Number: 000556 Provider Number:155747 AIM Number: 100290130 Survey Team: Julie Wagoner, RN, TC Christine Fodrea, RN Tim Long, RN Census bed type: SNF/NF: 119 Total: 119 Census payor type: Medicare: 09 Medicaid: 72 Other: 38 Total: 119 Sample: 24 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.	F0000	This is Woodcrest Nursing Center's Plan of Correction for our annual survey conducted on July 22, 2011.The plan of correction is our credible allegation of compliance.Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission or agreement by Woodcrest Nursing Center of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and /or executed in compliance with State and Federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on July 29, 2011 by Bev Faulkner, RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, record review and interview, the facility failed to ensure the physician was notified timely of changes in skin condition, when ordered treatment was not effective and when ordered medications were not given due to being unavailable for 3 residents of 24 residents reviewed for physician	F0157	1, What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?For Resident #24, the physician was notified of changes in skin condition prior to survey. Resident #24 has RHC'd.For Resident #69, medications were obtained, administered, and	08/21/2011

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	notification. (#69, 24, #107) Findings include:		physician notified of missed medications. Resident #69 was discharged to home.For Resident #107, correct medications are being administered, physician notified of missed medications.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? In an effort to identify any other applicable residents, the MAR for all residents was reviewed to identify and other missed medications. No additional residents were identified to have missed medications. All residents with edema were identified and checked for changes in skin condition and the need to notify the physician. No other residents were identified.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur? An in-service will be conducted for all RN's and LPN's on August 18, 2011. The revised Wound Care policy will be reviewed along with the revised Order and Receipt of Drugsd From the Pharmacy policy. Timely notification to the physician for missed medications and timely notification of changes in skin condition will be discussed.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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	1. During the initial tour of the facility, conducted on 07/18/11 between 10:30 A.M. - 11:30 A.M., the Director of Nursing indicated Resident #24 had a pressure ulcer on her left heel. The clinical record for Resident #24 was reviewed on 07/19/11 at 10:50 A.M. The resident was admitted to the facility on 01/12/05 with diagnosis, including but not limited to diabetes and peripheral vascular disease. Review of a nurses note, dated 06/15/11 at 6:35 A.M., indicated the following:		programs will be put into place: The night shift charge nurse will audit all MAR weekly to ensure no ordered medications are missed. This will be ongoing times 6 months with results to QA. Skin assessments will done weekly by the charge nurse on each hall and the charge nurse will notify the physician when there is a change in condition of the skin. Physician notification and new orders will be documented in the nurse's notes which will be read and audited by the DON and ADON M-F ongoing with results to QA times 6 months. Skin assessments will be assigned weekly by the DON and the assigned charge nurse will notify DON weekly of completion ongoing times 6 months with results to QA.	

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	"...noted BLE (bilateral lower extremities) to be red et (and) warm to touch denies pain when asked. has BLE edema 3 + pitting even with legs being elevated throughout the night. Oncoming nurse updated et states she will call the MD (medical doctor) with update." A subsequent nurse's note, dated 06/15/11 at 1500 (3:00 P.M.) indicated the following: "res legs cont (continues) to be bright red in color et warm to the touch. (Physician's name)'s office notified. (Physician's name) out of office today. May call tomorrow to see if (physician's name) has any new orders." A nurse's note, dated 06/16/11 at 12:35 P.M., indicated the physician was updated. There was no physician's order given regarding Resident #24's legs. There was no further note or assessment of the resident's legs in the progress notes until 06/19/11 at 11:00 A.M., which indicated the resident's legs were still swollen, red and warm to touch with 3+ pitting edema. The on call physician was notified. A follow up nursing progress note, dated 06/19/11 at 12:00 noon, indicated the on call physician did not want to give any orders regarding Resident #24's legs but			

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	preferred the resident's regular physician to give orders the following day or see the resident in his office. A nursing progress note, dated 06/20/11 at 1830 (7:30 P.M.), indicated an order had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. Nursing notes, from 06/20/11 - 06/28/11, indicated the resident was receiving the antibiotic for the cellulitis, but her legs remained red, swollen, and warm to touch. A nursing note, dated 06/29/11 at 10:00 A.M., indicated the physician was notified of the resident's continued cellulitis with no improvement and a decrease in the resident's oxygen saturation level and some shortness of breath. The resident was sent to the local emergency room and returned with orders to change the antibiotic to Levaquin. Interview with the Director of Nursing regarding the delay in obtaining initial treatment for the resident's cellulitis and also in notifying the physician of the need to change treatment due to no improvement in the resident's cellulitis on 07/22/11 at 11:00 A.M., indicated there was no reason for the delay and lack of			

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	nursing follow up with the physician. The resident's legs and feet were assessed on 07/19/11 at 1:15 P.M. The resident was noted to have an open area the size of a golf ball on her left heel where a blister had apparently popped. In addition, the resident was noted to have bilateral edema to both lower extremities and feet. The edema increased above the resident's tight white socks. Both shins and feet were noted to be reddened and had scaly skin. The resident was noted to wince when her left foot was moved. Nursing staff, LPN #5, indicated her feet and shins did not feel warm to touch and did not look as red as it had looked before antibiotic treatment. 2. Resident #69's record was reviewed 7/19/20211 at 3:45 p.m. Resident #69's diagnoses included but were not limited to diabetes, congestive failure, and pulmonary edema. A current physician's order indicated Scopolamine (a medication for pain) had been ordered 5/13/2011 to be administered 0.25 milligrams every 8 hours through a patch and Neurontin (a medication for pain) 100 milligrams three times per day had been ordered 7/12/2011.			

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	A review of the Medication Administration Record (MAR), dated 7/2011, revealed initials of nurse administering Scopolamine were circled on 7/16 at 8 p.m.; and 7/17/2011 at 6 am, noon, and 8 p.m.. On the back of the MAR, under the date 7/16/2011, the record indicated Scopolamine was not given as there was no supply on hand. A review of the Medication Administration Record (MAR), dated 7/2011, revealed initials of nurse administering Neurontin were circled on 7/14- 8 p.m. dose, 7/15- noon and 8 p.m. dose; 7/16- noon and 8 p.m. doses; 7/17- 8 am, noon and 8 p.m. doses; and 7/18- 8 a.m. and noon doses. On the back of the MAR, under the date 7/14 and 7/15/2011, the record indicated medications were not given as there was no supply on hand and the facility was awaiting family and hospice to supply the medication. Interview with the Director of Nursing on 05/19/11 at 5:45 P.M., indicated the medications were available in the EDK (emergency drug kit) or from the hospital pharmacy and should have been given. She also indicated the physician should have been notified of any missed doses. 3. Resident #107's record was reviewed 7/20/2011 at 2:45 p.m. Resident #107's			

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	diagnoses included but were not limited to end stage heart disease, congestive heart failure and depression. A current physician's order dated 5/31/2011 indicated Humulin N 30 units BID had been ordered 5/1/2011. A physician's order dated 6/20/2011 indicated to use Novolin N in place of Humulin N. A review of the Medication Administration Record (MAR) dated 6/2011 revealed initials of nurse administering insulin on 6/20/2011 at 8:00 a.m. were circled. On the back of the MAR, under the date and time 6/20/2011 at 8:00 a.m., the record indicated Novolin N 30 units was not given as there was no Novolin N on hand. A review of the Medication Administration Record (MAR) dated 7/2011 revealed initials of nurse administering insulin on 7/8/2011 at 8:00 a.m. were circled. On the back of the MAR, under the date and time 7/8/2011 at 8:00 a.m., the record indicated Novolin N 30 units was not given as there was no Novolin N in stock. A document provided by the Administrator on 7/20/2011 at 10:00 a.m.			

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	indicated the pharmacy had been notified of the need for Humulin N on 6/17/2011. The pharmacy stocked Novolin N, and was willing to substitute, but did not communicate with the facility until 6/20/2011, causing a missed dose. Additionally, on 7/8/2011, the facility had not ordered the insulin causing a missed dose. In an interview 7/20/2011 at 2:30 p.m., the Administrator indicated the physician should have been notified if medications were not administered as ordered. A current policy dated 2/9/00 and updated 3/11 titled Physician Drug Orders did not indicate the physician was to be notified if a medication could not be given. 3.1-5(a)(2) 3.1-5(a)(3)			

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F0244 SS=E	When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on observation, interview and record review, the facility failed to satisfactorily resolve grievances expressed in resident council meetings related to noise at night and extended wait time to exit the main dining room following meals. This actually affected 7 of 11 residents who attended the group meeting (Resident #201, 202, 203, 204, 207, 208, and 210) and 1 resident interviewed following the group meeting. (Resident #78) Findings include: 1. During group meeting on 7/19/2011 at 9:30 a.m., 7 of 11 residents (Residents #201, 202, 203, 204, 207, 208 and 210) present expressed concern over the amount of noise at night, indicating noise at night was a current problem. A review of Resident Council Minutes for the month of February 2011 indicated residents had expressed a concern regarding noise at night. The concern had been noted and given to the Director of Nursing for response and resolution.	F0244	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?All residents attending the group meeting along with 20 other residents were interviewed by the Activities Coordinator, so staff could respond to their issues in regards to noise. All MAR were reviewed by the night shift charge nurse to see if any medications could be given with morning med pass and not during sleeping hours. A new pill crusher was purchased to eliminate unnecessary noise for each cart. A CNA will be assigned from each wing to return residents to their room from the dining room in a timely fashion.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?In an effort to identify any other applicable residents affected by noise at night or waiting too long in the dining room, random interviews were conducted to ensure there are no issues with noise or waiting time following meals to return to room. The audit revealed there are no current issues in regards to excessive	08/21/2011

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	A review of the Resident/ Family Council Departmental Response, dated 2/8/2011, revealed the concern regarding noise at night was referred to the Director of Nursing with a resolution requested by 2/28/2011. The response indicated the Unit Manager, Evening Supervisor and Restorative staff were made aware of the resident concern regarding noise at night. Staff were requested to have quiet decor in the halls. No monitoring or further investigation was indicated as being completed. In an interview on 7/20/2011 at 8:30 a.m., Resident #78 indicated noise in the facility at night was still a problem. 2. During group meeting on 7/19/2011 at 9:30 a.m., 6 of 11 residents indicated there was not enough staff to get residents out of the main dining area after they finished eating resulting in long wait times. A review of Resident Council minutes revealed the following: In January 2011, residents attending the meeting had expressed a concern the wait time was too long after meals to get out of the dining room. The response to the Council in February indicated walkie talkies had been replaced. In March 2011, residents again indicated the CNAs were not coming to the Main Dining Room to		noise at night. An audit was conducted on various days including breakfast, lunch, and dinner. No issues were identified as all residents were served within 30 minutes of ordering and all residents requesting to return to their room were returned within 5 minutes of request. Results will be shared at the September Residents Council Meeting.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?All concerns from Resident Council will be forwarded to the correct manager to be resolved within 48 hours. When the concern cannot be resolved within 48 hours, the managers will discuss the concern with the administrator. The concerns and resolutions will be discussed at each Resident Council meeting and concerns will be resolved at the next meeting with the minutes reflecting the concern as resolved. The Grievance Concern Report Policy will be reviewed at the all staff in-service on August 18, 2011. Excessive noise at night will be discussed at the in-service and a CNA from each wing will be assigned to return residents form meals on a daily basis, which will also be reviewed at the all staff in-service. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will	

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	assist residents back to their rooms after dining. The response to the Council in April from the Director of Nursing was she would talk to the staff. In May 2011, residents again addressed the concern of CNAs not coming to the Main Dining Room to assist residents back to their rooms after eating. The response from the Director of Nursing on the Resident/ Family Council Departmental Response, dated 5/11/2011, indicated staff had been assigned to the dining room to assist residents back to their rooms. The response did not include further monitoring to assure staff were assisting residents. In July 2011, residents again addressed the concern of extended wait times to return to rooms after dining in the Main Dining Room. The Dietary Manager responded with a plan for auditing the issue and monitoring the dining area. During an observation on 7/21/2011 between 11:20 am and 12:30 p.m., it was noted wait staff were returning residents to their rooms when requested. A current policy dated 4/1/200 and updated 3/2011 titled Grievance Concern Report Policy indicated investigation of concerns would begin within 48 hours and attempts would be made to resolve the concern.		be put into place:The Activity Coordinator will interview 10 residents from each wing in regards to noise and excessive wait time in the dining room monthly times 6 months with results to QA.All minutes from the Resident Council will be given to the administrator following the meeting. The administrator will monitor all concerns to ensure they are addressed within 48 hours following the meeting ongoing with results to QA times 6 months.	

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	3.1-3(l)			
F0246 SS=D	A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review and interview, the facility failed to provide a dining table of proper height to enable 1 resident (#51) of 21 residents observed to feed self in a sample of 24. Findings include: Resident #51's clinical record was reviewed on 7/21/11 at 11:15 A.M. The record indicated the resident was admitted to the facility on 2/5/08. The resident was observed during two meals on 7/20/11 at 12:00 P.M., and 7/21/11 at 11:40 A.M., in the Tea Room Lounge (assist dining room). On 7/20/11 at 12:00 P.M., the resident sat at a table with no staff present and did not feed herself at all. At one point during the meal, a staff person came to the table and fed the resident a bite of her meal. The resident sat in a low to the ground	F0246	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?A table of adjustable height is ordered for each of the lounges. A bedside table of adjustable height will be utilized for Resident #51 until the tables arrive. Care plan for Resident #51 has been updated to reflect her dietary needs and assistance needs.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?In an effort to identify any other applicable residents, the CDM audited all residents eating in lounges or dining room for appropriate table height. One other resident was found but refused to change tables and not eat with her friends. This was care planned.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The CDM will monitor	08/21/2011

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	wheelchair and was at eye level with the table and was unable to see inside the bowls her food was brought in. On 7/21/11 at 11:40 A.M., the resident was placed at a different table than on 7/20/11 and was seated next to a CNA who was physically assisting another resident with her meal. Resident #51's pureed food was brought out in five separate bowls and placed before her. The resident attempted several bites of food after verbal cues by the CNA. The resident eye line was right at the base of the table and she was unable to see inside the bowls of food. An interview with CNA #5 on 7/21/11 at 11:55 A.M., indicated the Tea Room Lounge used to have a lower table before the floor was redone, around Christmas last year, but since then the lower table was in the main dining room. CNA #5 indicated they had tried using a TV tray with Resident #51 but she would upset her tray of food trying to feed herself. CNA #5 indicated the resident is to be cued to eat her food and sometimes requires assist to eat. An interview with the Director of Nursing (DN) on 7/21/11 at 1:25 P.M., indicated she did not have any information about the table height problem for Resident #51		all residents upon admission for appropriate table height. Residents needing a lower table will be placed at the new adjustable height tables.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place?The CDM will evaluate all residents upon admission for appropriate table height ongoing with results to QA times 6 months.	

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	but she thought staff should have been using a bedside table. A review of the resident's care plan of 1/6/10 for at risk for inadequate nutrition indicated the resident will feed self with set up help and assist if needed. 3.1-19(w)(5)			
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to develop a behavior management program for aggressive behaviors for 1 of 7 residents reviewed for behaviors in a sample of 24 (Resident #25) . Findings include: 1. During the initial tour of the facility, conducted on 07/18/11 between 10:30 A.M. - 11:30 A.M., the Director of Nursing indicated Resident #25 was confused, ambulated independently, wandered throughout the day, and was anxious at times. She indicated the resident was able to complete activities of daily living with cues and minimal assistance. During the tour of the facility,	F0250	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #25- Behavior log was reviewed and completed when resident displays aggressive behaviors, a care plan was implemented to address aggressive behaviors and other behavior issues.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?In an effort to identify other applicable residents, Social Service coordinator reviewed all behavior logs and implemented an aggression care plan with interventions if needed.3. What measures will be put into place or what systemic changes will be	08/21/2011

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	Resident #25 was observed ambulating in the hallway and was noted to follow or be invited to follow various staff members who were working on the unit. The resident was noted to follow them for a few minutes and then wander off and approach a different staff member. The clinical record for Resident #25 was reviewed on 07/19/11 at 1:00 P.M. The resident was admitted to the facility, on 10/06/09 with diagnosis, including but not limited to, Alzheimer's dementia and depressive disorder. The most recent Minimum Data Set (MDS) assessment for Resident #25, completed on 05/31/11, indicated the resident did not display any behavioral issues, was independently ambulatory, transferred independently, and required moderate staff assistance for dressing, personal hygiene, and toileting needs. The health care plans for Resident #25, current until 08/11, indicated a plan to address the resident's wandering behavior with interventions focused on maintaining her safety by knowing her whereabouts. There was one intervention regarding providing diversional activities and rest periods. There was no plan to address any other behavioral issues.		made to ensure that the deficient practice does not recur?Social Services conducted an all staff in-service on August 18, 2011. Identification of behaviors, completion of behavior logs, and interventions for behaviors were discussed. Behavior Health from AMH will conduct a more in-depth behavioral management in-service for all staff on August 26.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place?Social Services will monitor behavior logs weekly for 6 months with results to QA. DON/ADON will read nurses notes M-F, and inform Social Services of any noted behaviors. This will be done M-F, ongoing with results to QA times 6 months.	

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	A physician's order, dated 04/26/11, indicated an order for the resident to be evaluated by a psychologist regarding her increase in aggressive behaviors. Review of the psychologist's report, completed on 04/27/11, indicated the direct care staff had noted an increase in physically aggressive behaviors towards staff and other residents. On 07/20/11 at 12:30 P.M., Resident #25's husband was noted to be preparing the resident to go out of the facility. On 07/20/11, in the afternoon and on 07/21/11 in the A.M., Resident #25 was not observed in the facility. Review of a nursing progress note, dated 07/20/11 at 10:30 A.M., indicated the physician had given an order to transfer the resident to an inpatient psychiatric hospital due to increased agitation. Nursing notes, dated 07/14/11 - 07/20/11, indicated there were notes dated 07/15/11 at 1430 (2:30 P.M.) indicating the resident was "pacing the hall. Res not easy to redirect. Res got agitated easy. Res up several times during meals asking what she should do or where she should be." There were three notes, all dated 07/17/11, and timed as 8:30 A.M., 11:20 A.M., and 2200 (10:00 P.M.), indicating the resident was attempting to hit staff			

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	when redirection was attempted and had yelled at other residents and called them names because they were talking too loudly. There were no other notes to indicate the resident had exhibited any other aggressive and/or agitated behaviors. Review of a Behavior Log summary for Resident #25 for July 2011 indicated there was one physically abusive behavior during a shower on 07/1/11, two physically abusive behaviors documented on 07/12/11, one behavior of transferring another resident on 07/12/11, a restless behavior documented on 07/13/11, a physically abusive behavior documented on 07/14/11, and three behaviors noted on 07/17/11. Of the nine behaviors documented, seven involved meal and/or snack time. Interview with the Social services Director on 07/21/11 at 1:50 P.M., indicated she was aware the resident was transferred, but she did not know any specific information regarding Resident #25's transfer to the psychiatric hospital. Interview with the Administrator and the Director of Nursing on 07/21/11 at 2:00 P.M., indicated the resident's wandering had increased and she was becoming increasingly aggressive with care needs so			

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	it was decided by the facility administration and the resident's family to have her transferred to see if there was anything that could be done regarding her aggressive behaviors and increased wandering. 3.1-34(a)			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop health care plans regarding incontinence needs or abusive behavior for 2 of 24 residents reviewed	F0279	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?For Resident #25 a care	08/21/2011

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	for care plan development in the sample of 24. (Residents #10, Resident #25) Findings include: 1. During the initial tour of the facility, conducted on 07/18/11 between 10:30 A.M. - 11:30 A.M., the Director of Nursing indicated Resident #25 was confused, ambulated independently, wandered throughout the day, and was anxious at times. The clinical record for Resident #25 was reviewed on 07/19/11 at 1:00 P.M. The resident was admitted to the facility, on 10/06/09 with diagnosis, including but not limited to, Alzheimer's dementia, depressive disorder. The most recent Minimum Data Set (MDS) assessment for Resident #25, completed on 05/31/11, indicated the resident did not display any behavioral issues, was independently ambulatory, transferred independently, and required moderate staff assistance for dressing, personal hygiene, and toileting needs. A physician's order, dated 04/26/11, indicated an order for the resident to be evaluated by a psychologist regarding her increase in aggressive behaviors. Review of the psychologists report, completed on		plan was implemented for aggressive behaviors by Social Services with interventions. Resident #25 was scheduled for a significant change with MDS.For Resident #10, A care plan and toileting program was implemented after completion of a 7 day diary. Resident was placed on a toileting program for occasionally incontinent of bowel and totally incontinent of bladder. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents with an aggressive behavior be audited by Social Services to ensure a care plan is in place to address aggressive behaviors and the need for a significant change with MDS.All residents on an incontinence program are being assessed by the restorative nurse for appropriateness of program, assessment, care plan to reflect needs, correct plan on CNA assignment sheet, and MDS nurse will monitor the need for a change with the toileting program.3. What measures will be put into place or what systemic changes iwll be make to ensure that the deficient practice does not recur?All nurses' notes and 24 hour report sheets will be read by DON/ADON on M-F. Aggressive behaviors will be reported to SS.Restorative nurse will	

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	04/27/11, indicated the direct care staff had noted an increase in physically aggressive behaviors towards staff and other residents. Nursing notes, dated 07/14/11 - 07/20/11 indicated there were notes, dated 07/15/11 at 1430 (2:30 P.M.), indicating the resident was "pacing the hall. Res not easy to redirect. Res got agitated easy. Res up several times during meals asking what she should do or where she should be." There were three notes, all dated 07/17/11 and timed as 8:30 A.M., 11:20 A.M., and 2200 (10:00 P.M.), indicating the resident was attempting to hit staff when redirection was attempted and had yelled at other residents and called them names because they were talking too loudly. There were no other notes to indicate the resident had exhibited any other aggressive and/or agitated behaviors. Review of a Behavior Log summary for Resident #25 for July 2011 indicated there was one physically abusive behavior during a shower on 07/1/11, two physically abusive behaviors documented on 07/12/11, one behavior of transferring another resident on 07/12/11, a restless behavior documented on 07/13/11, a physically abusive behavior documented on 07/14/11, and three behaviors noted on		implement a bowel/bladder care plan based on the 7 day diary which will be done upon admission, quarterly, and with any change in condition. New forms were implemented and in serviced on August 18, 2011.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place?Weekly, the restorative nurse will bring the bowel and bladder flow sheets to the care plan meeting and the Restorative nurse/ADON will check accuracy of the flow sheets with the care plan and the CNA assignment sheet. This will be ongoing with results to QA times 6 months. All nurses notes and 24 hour report sheets will be read M-F by the DON/ADON, they will notify SS of any aggressive behaviors. This will be ongoing with results to QA times 6 months. Whenever SS is notified they will inform MDS nurse of an aggressive behavior. MDS will check for aggressive behavior care plan and will initiate a significant change if appropriate. This will be ongoing times 6 months.	

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	07/17/11. Of the nine behaviors documented, seven involved meal and/or snack time. The health care plans for Resident #25, current until 08/11, indicated a plan to address the resident's wandering behavior with interventions focused on maintaining her safety by knowing her whereabouts. There was one intervention regarding providing diversional activities and rest periods. There was no plan to address any other behavioral issues, such as physical abusive behaviors. 2. During the initial tour of the facility conducted on 07/18/11 between 10:30 A.M. - 11:30 A.M., the Director of Nursing indicated Resident #10 was confused, required maximum staff assistance for Activities of Daily Living (ADLs), and was incontinent of her bowels and bladder and was toileted by staff. The clinical record for Resident #10 was reviewed on 07/20/11 at 11:40 A.M. The resident was admitted to the facility on 06/17/11. The initial Minimum Data Set (MDS) assessment, completed on 06/30/11, indicated the resident was occasionally incontinent of her bowels and bladder.			

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	The current health care plans, current through 09/11 indicated there was no plan to address the resident's bowel and/or bladder incontinence. Interview with the Director of Nursing, on 07/22/11 at 11:00 A.M., confirmed there was no care plan located addressing incontinence needs for Resident #10. 3.1-35(a)			
F0280 SS=A	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, record review, and	F0280	1. What corrective action(s) will	08/21/2011

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	interviews, the facility failed to ensure the health care plans for 1 of 24 residents reviewed for care plans in a sample of 24 were updated to reflect the resident's current needs. (Resident #25) Finding includes: 1. During the initial tour of the facility, conducted on 07/18/11 between 10:30 A.M. - 11:30 A.M., the Director of Nursing indicated Resident #25 was confused, ambulated independently, wandered throughout the day, and was anxious at times. She indicated the resident was able to complete activities of daily living with cues and minimal assistance. During the tour of the facility, Resident #25 was observed ambulating in the hallway and was noted to follow or be invited to follow various staff members who were working on the unit. The resident was noted to follow them for a few minutes and then wander off and approach a different staff member. The clinical record for Resident #25 was reviewed on 07/19/11 at 1:00 P.M. The resident was admitted to the facility on 10/06/09 with diagnoses, including but not limited to, Alzheimer's dementia and depressive disorder. The most recent Minimum Data Set		be accomplished for those residents found to have been affected by the deficient practice?Program for resident #25 was discontinued on 7/21/11. The care plan was updated to reflect the change. Resident #25's flow sheet was taken out of the CNA charting book as well as her name removed from daily walking list at the nurses' station.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?In an effort to identify any other applicable residents, the Restorative Nurse reviewed all ambulation programs for appropriateness of need. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The Restorative Nurse will provide an in-service for all nursing staff on the appropriateness of ambulation programs, including goals and continuation on August 18, 2011. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place? The Restorative Nurse will review the ambulation list weekly times 4 weeks then monthly times 6 months with results to QA for appropriateness of program, quarterly for the need for change of goals and appropriateness of	

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	(MDS) assessment for Resident #25, completed on 05/31/11, indicated the resident was independently ambulatory, transferred independently, and required moderate staff assistance for dressing, personal hygiene, and toileting needs. Review on 07/19/11 at 1:00 P.M., of the health care plans for Resident #25, current through 08/11, indicated a plan for a restorative ambulation program with the goal for the resident to ambulate from her room to the glass doors at the end of a different nursing unit and back to her room daily. Interview with the Administrator, on 07/21/11 at 9:00 A.M., indicated the restorative ambulation care plan had been discontinued as of 07/21/11 due to it being "inappropriate." She indicated the resident ambulated by herself without staff assistance. 3.1-35(d)(2)(B)		program. Restorative nurse will in service staff on appropriateness of ambulation program, goals, and continuation on August 18, 2011.	

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interviews, the facility failed to ensure physician's orders and care plans were followed for 3 of 24 residents reviewed for services to be provided in a sample of 24 related to restorative care, use of heel protectors and administration of medications. (Residents #27, 69, and 107) Finding includes: 1. a. During the initial tour of the facility, conducted on 07/18/11 between 10:30 A.M. - 11:30 A.M. , the Director of Nursing indicated Resident #27 was incontinent at times but had a toileting plan, required moderate staff assistance for activities of daily living, propelled a wheelchair herself and ambulated with assistance, fed herself, and required nectar thick liquids. The clinical record for Resident #27 was reviewed on 07/20/11 at 9:30 A.M. A physician's order, dated 03/18/11, indicated the resident had been discontinued from speech therapy with orders to receive nectar thickened liquids	F0282	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #27, Physician was notified that chin tuck order was not being followed. Physician ordered speech eval, which was completed on 7/22/11. At that time the speech therapist determined that chin tuck was inappropriate and order was dc'd. Resident #27 refuses to wear heel protectors at this time. The physician was notified on 8/8/11 with orders received to dc heel protectors.Resident #27 toileting program was re-evaluated and an appropriate plan was put into place. The care plan has been updated and the CNA sheet was updated to reflect toileting program.Resident #27 restorative ambulation program was re-evaluated and resident was placed on an appropriate program, with care plan and CNA sheet updated. Resident #69, the physician was notified of missed medication, medications were obtained and no adverse effects were noted.Resident #107, Physician was notified of medication error and no adverse side effects were noted. 2. How other residents having the potential to be affected by the	08/21/2011

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	and supervision to ensure the resident tucked her chin with each swallow. Resident #27 was observed on 07/19/11 at 11:45 A.M., and again on 07/21/11 at 12:00 P.M., seated in her wheelchair in the assisted dining room. The resident's meal tray was set up for her and she was noted to feed herself. The resident did not receive any staff cues to tuck her chin each time she swallowed. The resident did not tuck her chin when she swallowed. The resident coughed once after taking several consecutive sips of her thickened juice. Staff did cue her to eat more food, but no staff at either meal was noted to cue her to tuck her chin with each swallow. b. In addition, there was a physician's order, dated 04/30/11, for the resident to have heel protectors on both feet while in bed. Resident #27 was observed on 07/19/11 at 9:35 A.M., and at 11:15 A.M., lying in her bed on her back. The resident's heels were both noted to be lying on her bed with no heel protectors on either heel. Resident #27 was observed again on 07/21/11 at 9:15 A.M., lying in her bed. Both feet were noted to have footie hose on them and no heel protectors. Her heels		same deficient practice will be identified and what corrective action(s) will be taken?All charts of those residents eating in the lounge will be reviewed to ensure that staff is following appropriate physicians orders. Care plans and CNA sheets will be updated as needed. Residents with orders for heel protectors will be reviewed for compliance and appropriateness. Residents with toileting plans will be evaluated and current toileting programs will be updated specific to individual need. Care plans and CNA lists will be updated to reflect new toileting programs.All residents currently on ambulation programs will be re-evaluated to determine appropriate individualized ambulation program. CNA sheets will be updated with specific ambulation program. Care plans will be updated accordingly. All residents receiving Hospice care will have a list of Hospice provided medications placed in a plastic sheath on the chart. All MAR will be reviewed for any missed medications. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?All new speech therapy evaluations with recommendations will be forwarded to the Restorative Nurse who will obtain physician order, notify POA, educate staff of residents specific needs, update	

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	were noted to be lying directly on top of the resident's bedspread. c. The current health care plans for Resident #27, dated as current through 09/20/11, included restorative care plan for ambulation and toileting needs. On 07/19/11 at 11:40 A.M., Resident #27 was assisted to her wheelchair and pushed to the assisted dining room by staff. The resident was not noted to be taken to the bathroom before the meal. On 07/21/11 at 9:15 A.M., Resident #27 was noted to be in bed. At 9:35 A.M., CNA #6 was noted to be pushing Resident #27 out of her room. Interview with CNA #6 indicated the resident's bed alarm was sounding and the resident was toileted because that was usually what she needed when she tried to get out of bed. CNA #6 indicated Resident #27 was toileted when she, the resident, indicated she needed to go to the bathroom and was not on any specific schedule. CNA #6 indicated Resident #27 was usually continent of her bowels and bladder during the day time hours. CNA #6 indicated Resident #27 was able to pivot from her bed to the wheelchair but did not ambulate. CNA #7 was queried regarding Resident #27, on 07/21/11 at 3:00 P.M., and		CNA sheets and care plan. Staff will be in serviced that treatment is on the TAR, requiring nursing staff to observe and document proper placement of heel protectors. CNA sheets and care plans will be updated appropriately. CNAs will be in serviced to refer to CNA sheet for resident's toileting program. Restorative Nurse will be responsible for evaluating and updating toileting programs, CNA sheets and care plans. CNAs will be in serviced to refer to CNA sheet for specific directions regarding residents restorative programs. Restorative RN will be responsible for evaluating and updating ambulation plans, CNA sheets and care plans as well as informing staff of any changes. Policy for obtaining temporary supply of medications from AMH Pharmacy will be revised and in serviced on August 18, 2011. An in-service will be held on August 18, 2011, to alert nurses to check EDK, call pharmacy or AMH nursing supervisor for temporary supply when medication is out of stock. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place? ADON/DON will monitor 5 residents with specific feeding plans weekly times 6 months to ensure physicians orders are followed with results to QA. TAR	

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	indicated the resident was ambulated in her room from her bed to the bathroom but was not ambulated in the hallway. She indicated the resident was toileted upon her request and was not on any specific toileting schedule. Review of the July Restorative Flow sheet record indicated the resident was to ambulate with a rolling walker and a gait belt behind her wheelchair from her room to the assisted dining room for meals and from her room to the fire doors two times a shift as tolerated. The resident's record was documented as having completed the ambulation program for day and evening shifts from July 1 - 20; even though the nursing staff were not observed ambulating the resident. 2. Resident #69's record was reviewed 7/19/20211 at 3:45 p.m. Resident #69's diagnoses included but were not limited to diabetes, congestive failure, and pulmonary edema. A current physician's order indicated Scopolamine (a medication for pain) had been ordered 5/13/2011 to be administered 0.25 milligrams every 8 hours through a patch and Neurontin (a medication for pain) 100 milligrams three times per day had been ordered 7/12/2011.		will be audited by night shift charge nurse weekly times 6 months to ensure heel protectors are appropriate and order is being carried out with results to QA. ADON/DON will monitor 5 residents with toileting programs to ensure program is being followed weekly times 6 months with results to QA committee. ADON/DON on days worked will monitor 5 residents with ambulation programs weekly times 6 months to ensure appropriateness and program is being carried out with results to QA committee. Medication error report will be completed within 24 hours and turned into the DON for any medication that is considered unavailable. Results will go to QA ongoing. MAR will be audited weekly by night shift charge nurse with any missing medication reported to DON ongoing with results to QA.	

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A review of the Medication Administration Record (MAR), dated 7/2011, indicated initials of the nurse administering Scopolamine were circled on 7/16 at 8 p.m.; and 7/17/2011 at 6 a.m., noon, and 8 p.m. On the back of the MAR, under the date 7/16/2011, the record indicated Scopolamine was not given as there was no supply on hand.

A review of the Medication Administration Record (MAR), dated 7/2011, revealed initials of the nurse administering Neurontin were circled on 7/14- 8 p.m. dose, 7/15- noon and 8 p.m. dose; 7/16- noon and 8 p.m. doses; 7/17- 8 am, noon and 8 p.m. doses; and 7/18- 8 a.m. and noon doses. On the back of the MAR, under the date 7/14 and 7/15/2011, the record indicated medications were not given as there was no supply on hand and the facility was awaiting family and hospice to supply the medication.

Interview with the Director of Nursing, on 07/19/11 at 5:45 P.M. indicated the medications were available in the EDK (emergency drug kit) or from the hospital pharmacy and should have been given.

3. Resident #107's record was reviewed 7/20/2011 at 2:45 p.m. Resident #107's diagnoses included but were not limited to

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	end stage heart disease, congestive heart failure and depression. A current physician's order, dated 5/31/2011, indicated Humulin N 30 units BID had been ordered 5/1/2011. A physician's order, dated 6/20/2011, indicated to use Novolin N in place of Humulin N. A review of the Medication Administration Record (MAR), dated 6/2011, revealed initials of the nurse administering insulin on 6/20/2011 at 8:00 a.m., were circled. On the back of the MAR, under the date and time 6/20/2011 at 8:00 a.m., the record indicated Novolin N 30 units was not given as there was no Novolin N on hand. A review of the Medication Administration Record (MAR), dated 7/2011, revealed initials of nurse administering insulin on 7/8/2011 at 8:00 a.m. were circled. On the back of the MAR, under the date and time 7/8/2011 at 8:00 a.m., the record indicated Novolin N 30 units was not given as there was no Novolin N in stock. A document provided by the Administrator on 7/20/2011 at 10:00 a.m. indicated the pharmacy had been notified			

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	of the need for Humulin N on 6/17/2011. The pharmacy stocked Novolin N, and was willing to substitute, but did not communicate with the facility until 6/20/2011, causing a missed dose. Additionally, on 7/8/2011, the facility had not ordered the insulin causing a missed dose. In an interview on 7/20/2011 at 2:30 p.m., the Administrator indicated there was no specific policy concerning following physician orders, but it was understood the physician's orders should be followed. 3.1-35(g)(2)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure bowel incontinence was thoroughly assessed for 1 of 13 residents reviewed for bowel incontinence in a sample of 24. (Resident #10)	F0309	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #10 was placed on a bowel program for frequently incontinent of bowel. Care plan and CNA assignment sheet were updated to reflect	08/21/2011

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	Finding includes: During the initial tour of the facility, conducted on 07/18/11 between 10:30 A.M. - 11:30 A.M., the Director of Nursing indicated Resident #10 was confused, required maximum staff assistance for Activities of Daily Living, and was incontinent of her bowels and was toileted by staff. The clinical record for Resident #10 was reviewed on 07/20/11 at 11:40 A.M. The resident was admitted to the facility on 06/17/11. The initial Minimum Data Set (MDS) assessment, completed on 06/30/11, indicated the resident was occasionally incontinent of her bowels. Occasionally incontinent of bowel was described as one incontinent episode in a week. An Evaluation of Bowel assessment, completed on 06/28/11, indicated both incontinence of bowel and continent of bowel were indicated on the form. The resident was noted to have both "diminished" and "absent" need to defecate documented. The resident was noted to have a daily elimination pattern but no timeframe for the pattern was noted. The health care plans, current through		frequently incontinent of bowel. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents frequently incontinent of bowel will be assessed to ensure toileting program is addressed in the care plan with an appropriate plan and the CNA assignment sheet is updated to reflect program.3. What measures will be put into placed or what systemic changes will be made to ensure that the deficient practice does not recur?Restorative Nurse will implement a bowel/bladder care plan based on the residents needs following the 7 day diary, as changes arise, quarterly, and as needed. A new form was implemented. Forms will be in serviced on August 18 by the Restorative Nurse along with reeducation on bowel incontinence programs.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place?Weekly the Restorative Nurse will bring bowel/bladder flow sheets to care plan meeting and the ADON will check accuracy of flow sheet with care plan and CNA sheet. Results of findings to QA times 6 months.	

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	09/11, indicated there was no plan to address the resident's bowel incontinence. Interview with the Director of Nursing, on 07/22/11 at 11:00 A.M., indicated there was no additional information regarding any more specific documentation regarding a bowel assessment and management plan for Resident #10. 3.1-37(a)			
F0311 SS=D	A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, record review and interview, the facility failed to provide restorative services related to ambulation and toileting for 3 of 6 residents reviewed for restorative services in a sample of 24. (#34, 51, 27) Findings include: 1. Resident #34's clinical record was reviewed on 7/11/11 at 2:50 P.M. The record indicated the resident was admitted to the facility on 2/7/11. Resident #34 had a health care plan, dated 3/11, for a restorative program: toileting	F0311	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? #34-Care plan was updated to reflect use of bedpan. Use of commode and toilet were removed from care plan. #51-Ambulation list was changed for resident to ambulate from chair to bathroom and back. Care plan and CNA Assignment sheet updated to reflect goal change.#27-Staff re-educated on ambulation and toileting programs. The resident is being ambulated and toileted according to plan by the assigned CNA.2. How other residents having the potential to be affected by the	08/21/2011

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	schedule which indicated the resident requires nursing intervention to maintain bowel continence and promote self-performance in toileting. The goal was for the resident to maintain signs of bowel continence daily with current toilet schedule thru next review. The approaches included, but were not limited to: 1) Assist and offer bathroom with scheduled hours. Scheduled hours are located on restorative maintenance log in restorative book. Requires cues and encouragement for bowel program; 2) Resident requires limited (sic) of 1 staff member with toileting (transferring on/off commode); 3) Prompt resident to stand and pivot with transfers. Cue to use bars to help with transfers. Review of the July 2011 Restorative Maintenance Log indicated the resident was to be toileted upon rising, before lunch, before supper and second bed check at night. The log indicated from July 1, 2011 through July 19, 2011, the resident had been incontinent of bowel on night shift every night with 8 of the nights incontinent of bowel twice. The log indicated on 1st shift the resident was incontinent of bowel once on 7/6/11, twice on 77/7/11, 7/10/11, 7/12/11, 7/13/11 and 7/14 /11. The resident was incontinent of bowel three times on 7/8/11, 7/9/11 and 7/11/11. On second		same deficient practice will be identified and what corrective action(s) will be taken?All residents on toileting and ambulation programs will be assessed by the restorative nurse for appropriateness, completeness, care plan accuracy, and that the accurate program is on the CNA assignment sheet.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Restorative programs will be placed on the CNA daily assignment sheets. An ambulation ticket will be given to residents at random on the ambulation program to be returned to the restorative nurse after they have been ambulated. Toileting tickets will be placed randomly for the CNA to return to the Restorative Nurse after toileting has been completed. An in-service will be held on August 18, 2011, where the Restorative Nurse will educate on toileting programs and ambulation programs. New forms have been implemented.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place?Each resident on ambulation and/or toileting programs will be monitored for correct program and completion of program by the Restorative	

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	shift the resident was incontinent of bowel once on 7/1/11, 7/2/11 and 7/19/11 and incontinent of bowel twice on 7/10/11 and 7/18/11. The restorative maintenance log did not indicate if the resident was toileted upon rising, before lunch, before supper and at second bed check at night. An interview with CNA's #6, 7, and 8 on 7/19/11, 2:20 P.M., indicated on second shift the resident is asked before supper if he wants to use the bedpan. CNA's 6, 7, and 8 indicated the bedpan is the resident's preference and they do not automatically toilet the resident before supper. The resident's restorative health care plan indicated the resident was to be taken to the commode before supper on second shift. An interview with RN #9, the restorative nurse, on 7/19/11 at 2:05 P.M., indicated CNA's are to try to take the resident to the toilet upon arising, before lunch, supper and at second bed check at night. 2.a. Resident #51's clinical record was reviewed on 7/21/11 at 11:15 A.M. The record indicated the resident had a restorative health care program for toileting schedule which had the problem as the resident requires nursing intervention to maintain urinary continence and promote self-performance		Nurse weekly times 4 and monthly thereafter times 6 months with results to QA.	

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	in toileting. The goals were the resident will show signs of urinary continence daily with current toilet schedule and will toilet and eliminate daily with assistance. Approaches for the restorative toileting program included, but were not limited to: 1) Assist and offer resident bathroom with scheduled hours. Scheduled hours are located on restorative maintenance log in restorative book. Review of the resident's Restorative Flow Sheet for Toileting for July 1, 2011 through July 20, 2011 indicated the resident was to be assisted with toileting on rising, before and after breakfast, after an activity, after lunch, midafternoon, before and after supper, at bedtime and at 1st and last bed check at night. The July flow sheet indicated the resident was incontinent of bladder once every night. On day shift the resident was incontinent of bladder once on 7/12/11 and 7/13/11 and twice on 7/5/11, 7/6/11, 7/7/11, 7/10/11 and 7/11/11. On second shift the resident was incontinent of bladder once on 7/5/11, 7/8/11, and 7/9/11. The resident was incontinent of bladder twice on second shift 7/6/11, 7/7/11, 7/10/11, 7/17/11, 7/18/11, 7/19/11 and 7/20/11. On second shift the resident was incontinent of bladder three times on 7/11/11 through 7/16/11. The resident was noted to have no continent bladder episodes in July on			

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	night shift and second shift. On first shift the resident was noted to be continent of bladder once on 7/19/11 and 7/20/11. The resident was noted to be continent of bladder twice on 7/10 through 7/17 and three times on 7/1/11. The most recent restorative progress note of 4/29/11 indicated "goal is to maintain urinary continence by being toileted per assistance by set toileting schedule. Resident is mainly incontinent, but will eliminate at times when taken to the bathroom." An interview with CNA #10 on 7/21/11 at 1:45 P.M., indicated the resident is only taken to the bathroom for toileting when she requests it and did not toilet her according to a schedule. An interview with the RN #9, the restorative nurse, on 7/21/11 at 3:00 P.M., indicated she did not know the resident was not being toileted according to her schedule. b. Resident #51's clinical record was reviewed on 7/21/11 at 11:15 A.M. The record indicated the resident had a restorative health care program for ambulation started 12/10. The problem was identified as resident is unable to ambulate independently in hallway. The			

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	goal was for the resident to ambulate from her room to the nurses' station using a Rollator with 1 assist as tolerated, daily at least 6-7 days weekly. The approaches included but were not limited to, resident requires extensive assistance of 1 staff member to ambulate with use of rolling walker from bedroom to nurse's station. Review of the July 2011 Restorative Flow Sheet from 7/1/11 through 7/11/11 indicated the resident performed the task of ambulation with Rollator, gait belt, 1-2 assist, wheelchair behind resident from her bedroom to the nurses' station twice daily, every day requiring 15 minutes per session except on 7/5/11 and 7/6/11 during first shift which required 12 minutes per session. An interview with CNA #10 on 7/21/11 at 1:45 P.M., indicated the ambulation they do on first shift in the morning was to walk the resident to the bathroom. An interview with RN #9, the restorative nurse, on 7/21/11 at 3:00 P.M., indicated the resident's ambulation goal is not appropriate at this time and they are in the process of changing it. RN #10 indicated the resident has had a decline and staff shouldn't have been documenting on the restorative flow sheet as the resident was not performing the task of ambulating to			

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	the nurse's station. 3. During the initial tour of the facility, conducted on 07/18/11 between 10:30 A.M. - 11:30 A.M. , the Director of Nursing indicated Resident #27 was incontinent at times but had a toileting plan, required moderate staff assistance for activities of daily living, propelled a wheelchair herself and ambulated with assistance, fed herself, and required nectar thick liquids. The clinical record for Resident #27 was reviewed on 07/20/11 at 9:30 A.M. The current health care plans for Resident #27, dated as current through 09/20/11, included restorative care plan for ambulation and toileting needs. The toileting care plan indicated the resident was to be toileted before and after meals, midafternoon at shift change, at bedtime and at all bed checks at night. The ambulation care plan indicated the resident was to be ambulated with the rolling walker and assistance of 1 staff from her room to the lounge for meals and from her room to the fire doors two times per shift. On 07/19/11 at 11:40 A.M., Resident #27 was assisted to her wheelchair and pushed to the assisted dining room by staff. The resident was not noted to be taken to the			

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	bathroom before the meal. On 07/21/11 at 9:15 A.M., Resident #27 was noted to be in bed. At 9:35 A.M., CNA #6 was noted to be pushing Resident #27 out of her room. Interview with CNA #6, at this time, indicated the resident's bed alarm was sounding and the resident was toileted because that was usually what she needed when she tried to get out of bed. CNA #6 indicated Resident #27 was toileted when she, the resident, indicated she needed to go to the bathroom and was not on any specific schedule. CNA #6 indicated Resident #27 was usually continent of her bowels and bladder during the day time hours. CNA #6 indicated Resident #27 was able to pivot from her bed to the wheelchair but did not ambulate. CNA #7 was queried regarding Resident #27, on 07/21/11 at 3:00 P.M., and indicated the resident was ambulated in her room from her bed to the bathroom but was not ambulated in the hallway. She indicated the resident was toileted upon her request and was not on any specific toileting schedule. Review of the July 2011 Restorative Flow Sheet indicated the resident was to ambulate with a rolling walker and a gait belt behind her wheelchair from her room to the assisted dining room for meals and			

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	from her room to the fire doors two times a shift as tolerated. The resident was documented as having completed the ambulation program for day and evening shifts from July 1 - 20 even though the nursing staff were not observed ambulating the resident. Interview with the Restorative Nurse, RN #9, on 07/21/11 at 2:00 P.M., indicated the nursing assistants were responsible for the restorative toileting plans and some of the ambulation programs. She was unaware the ambulation program for Resident #27 was not being followed. 3.1-38(a)(2)(B) 3.1-38(a)(2)(C)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure	F0314	1. What corrective action(s) will be accomplished for those residents found to have been	08/21/2011

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	skin was thoroughly assessed under a splint, puff boots were properly applied and interventions were in place to prevent pressure areas for 3 of 4 residents reviewed with pressure areas in a sample of 24. (Resident #69, Resident #113, Resident #24) Findings include: 1. Resident #69's record was reviewed 7/19/2011 at 3:45 p.m. Resident #69's diagnoses included but were not limited to diabetes, stroke, and heart failure. A review of Nurse's notes, dated 6/5/2011 at 2200 (11:00 p.m.), indicated the nurse checked Resident #69's right lower extremity finding no skin tears, but observing a 0.6 centimeter by 0.5 centimeter open area where the brace applied to right lower extremity had been fastened while Resident #69 was up during the day. The area was protected, the physician and family notified, and treatment initiated. The Wound/ Skin Care Management Documentation record indicated the area on 6/5/2011 was a stage II pressure area 0.6 centimeters by 0.5 centimeters and less than 0.1 centimeters in depth with 25% pink granulation tissue and redness surrounding the area. On 6/10/2011, the		affected by the deficient practice? #69-No corrective action needed, resident dismissed to home.#113-puff boots were taken from inventory as they were from another facility. WC facility's heel protectors were applied to heels.#24-Braden scale was updated to reflect current status, white socks were removed and puff boots were applied while in wheelchair-Resident is deceased.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents with a brace, splint, or immobilizer were identified, a Braden completed, skin assessed, and chart checked for physician order. All residents with pressure ulcers on heels were assessed for intervention while in wheelchair on care plan, Braden was audited to reflect current risk for skin condition. Residents with edema were assessed for correct preventative stockings and an audit was performed to ensure all puff booties in the facility belonged to Woodcrest. 3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not recur?Braden will be completed upon admission, with skin issue, and quarterly by assessment nurse. Only facility's heel protectors will be utilized and proper stocking will be used when	

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	area remained a stage II pressure area measuring 0.3 centimeters by 0.2 centimeters and less than 0.1 centimeters in depth. The area had 80% pink granulation tissue and was reddened around the edges. The area was noted as healed on 6/14/2011. Resident #69 had been admitted to the facility on 5/31/2011. On the Nursing Admission/ Significant Change Assessment notes, dated 5/31/2011, the area marked skin condition indicated Resident #69 had no wounds present. There was a notation of psoriasis on both knees. The Assessment Notes also indicated a plastic splint/ brace was being utilized on the right foot and the splint was to be placed within the right shoe. The Medication Administration Record, dated 6/2011, indicated the brace had been applied each morning and taken off each evening. There were no notes on the record indicating skin had been checked under the splint. A review of Nurse's notes, dated 5/31/2011 through the time the pressure area had been identified on 6/5/2011 did not indicate skin checks or documentation of skin condition under or around the splint had been completed.		residents have edema. Care plan will indicate proper interventions for edema. Revised policy was reviewed at in-service on August 18, 2011 to ensure skin assessments are completed prior to removing and applying splints, braces, or immobilizers. Staff was in serviced on how to apply heel protectors and how to identify the facility's heel protectors. Staff was in serviced on signs of edema and appropriate interventions. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place?The MR coordinator will review completeness of chart and accuracy of assessment with in 24 hours of admissions on days worked. The DON will monitor nurse notes for documentation of skin assessment prior to applying and removing splint, brace, and/or immobilizer on days worked and DON will check to ensure order is on the chart. This will be ongoing with results to QA times 6 months. The admitting nurse will replace heel booties with the faiclities heel protectors with each admission ongoing with results to QA. Night shift charge nurse will audit and new admission orders for accuracy ongoing times 6 months with results to QA.	

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	Admitting physician's orders, dated 5/31/2011, did not indicate a splint was to be worn. A Braden Scale had not been completed indicating risk for pressure until 6/6/2011. A care plan titled Restorative Splint/ Brace, dated 6/11/2011, indicated to provide skin care before applying the brace and to monitor skin integrity before application and after removal. A physician's order written 6/6/2011 indicated the splint was to be applied in the morning and be taken off at night. Physical Therapy Aide #3 indicated during an interview 7/20/2011 at 2:20 p.m., nursing managed most splints and should be checking skin under and around splints when applying and removing the splint On 7/20/2011 at 2:25 p.m., the Director of Nursing indicated in an interview staff should have checked the skin under and around the brace on application and removal. A current wound policy provided by the Administrator on 7/21/2011 at 3:10 p.m., dated 4/2008, did not indicate prevention measures for avoiding pressure areas			

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	under splints and braces. 2. Resident #113s record was reviewed 7/18/2011 at 11 :00 a.m. Resident #113's diagnoses included but were not limited to, dementia with behavioral disturbances, depression and high blood pressure. A physician's order, dated 7/11/2011, indicated puff boots had been ordered to be applied to Resident #113's feet. Documentation on the Wound/ Skin Care Management Documentation Sheet indicated the area on the left heel had been initially noted on 7/11/2011 and was an unstageable area with skin intact, approximately 4 centimeters by 4 centimeters and red. During an observation on 7/18/2011 at 12:30 a.m., it was noted the puff boots had gel inserts. The dark blue insert areas were to the back of the foot. During an observation on 7/19/2011 at 9:15 a.m., it was noted the puff boots were on the feet, but with the gel insert to the back of the foot. During an observation of the Resident #113's left heel, it was noted the pressure area was located to the inside of the left heel approximately the size of a fifty cent			

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	piece. Skin was intact and dark brown colored. The Director of Nursing and Assistant Director of Nursing reapplied the puff boots with the gel inserts to the back of the foot. When queried about the proper application of the boot, both answered the gel inserts were to be on the bottom of the foot and immediately changed the position of the boot. The manufacturer's instructions for the puff boots provided by the Administrator on 7/20/2011 at 9 a.m., indicated the gel portion of the boot was to be placed beneath the resident's heel. 3. During the initial tour of the facility, conducted on 07/18/11 between 10:30 A.M. - 11:30 A.M., the Director of Nursing indicated Resident #24 was confused, required maximum staff assistance with activities of daily living, was pushed in her wheelchair by staff, and had pressure ulcers on her left heel and buttocks, which she had acquired in the facility. The resident was noted to be seated in her wheelchair in her room, she had oxygen on via a nasal cannula, and had slippers on her feet which were both resting on the wheelchair foot pedals.			

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	Resident #24 was observed on 07/20/11 at 9:15 A.M., and 11:15 A.M., seated in her wheelchair in her room. The resident was noted to be wearing slippers on both feet and both feet were resting on her wheelchair pedals. On 07/19/11 at 1:15 P.M., Resident #24's legs were observed while she was lying in bed. She had a fifty cent piece sized, superficial open area on her left heel. The resident's skin on her shins and feet was noted to be red, scaly, and edematous. The resident was also noted to be wearing tight white socks with extra edema noted above the top of the socks. The resident's buttocks was noted to be red but no open areas were noted. The clinical record for Resident #24 was reviewed on 07/19/11 at 10:50 A.M. The resident was admitted to the facility on 01/12/05 with diagnoses, including but not limited to diabetes, peripheral vascular disease, osteoarthritis, and history of cerebral vascular accident with right sided hemiparesis. Review of the most recent Minimum Data Set (MDS) assessment for Resident #24, completed on 05/27/11, indicated the resident required total staff assistance for mobility and transferring needs, extensive staff assistance for dressing and hygiene			

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	needs. The resident was also noted to be totally incontinent of her bladder. The resident was not noted to have a pressure ulcer. Review of a Braden Scale pressure ulcer risk assessment, completed on 06/21/11, indicated although the resident was chairfast, had diagnoses of diabetes and peripheral vascular disease, was totally incontinent of her bladder and was totally dependent on staff for mobility needs, the resident was not at high risk for developing a pressure ulcer. Review of health care plan, initiated on 04/16/09, and updated as current through 08/11 indicated the resident's goal was to have no skin breakdown. The plan was updated on 06/20/11 due to a cellulitis diagnosis; on 06/21/11 due to a pressure ulcer on coccyx, and on 06/28/11 due to a blister on the left outer heel. Interventions for pressure ulcer prevention included the use of puff and/or waffle boots while the resident was in bed, the use of a foot cradle, and extra protein once the resident developed a pressure ulcer. There were no interventions to prevent pressure on the resident's heels while she was up in her wheelchair, wearing tight fitting socks and slippers. 3.1-40(a)(2)			

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F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to thoroughly assess and ensure a program was developed to restore bladder continence for 1 of 13 residents reviewed for incontinence in a sample of 24. (Resident #10) Findings include: During the initial tour of the facility, conducted on 07/18/11 between 10:30 A.M. - 11:30 A.M., the Director of Nursing indicated Resident #10 was confused, required maximum staff assistance for Activities of Daily Living (ADLs), and was incontinent of her bowels and bladder and was toileted by staff. The clinical record for Resident #10 was	F0315	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?UA for resident #10 was placed on chart. Results were faxed to physician for appropriate orders. A seven diary elimination pattern was implemented for resident #10. Care plan updated to reflect history of UTI and appropriate toileting program.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents with an order for a UA will have results placed on chart by evening supervisor who will also ensure physician notification. All residents will have a 7 day diary completed upon admission, quarterly, and with a change in condition by the	08/21/2011

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	reviewed on 07/20/11 at 11:40 A.M. The resident was admitted to the facility on 06/17/11. The initial Minimum Data Set (MDS) assessment, completed on 06/30/11, indicated the resident was occasionally incontinent of her bladder (less than seven episodes of incontinence). There was no current health care plan regarding toileting needs. Review of a urinary continence evaluation, completed on 06/28/11, indicated the resident had a history of urinary incontinence as well as urinary tract infections. Both diminished and absent perception of voiding needs was marked on the form, and poor voiding stream, dribbling and urgency were marked. Although the resident had a urinalysis test completed on 06/22/11, the results were not noted on the assessment. The resident's urinary incontinence was noted to be reversible with implementing fluid and/or bowel management program, removing or improving environmental impediments, treating underlying condition, and managing pain. The resident was assessed to have mixed and urge incontinency. There were no measures implemented to reverse and/or improve the resident's bladder continency. No patterning completed to determine the most		restorative nurse. Care plans will reflect results with appropriate interventions.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Elimination assessment will be part of admission packet and restorative team will implement elimination pattern upon admission, quarterly, and with a significant change. Nursing will place the residents name on the clip board at nurse's station when UA has been completed. Evening supervisor will monitor returned results; fax to physician and ensure documentation is complete. This will be in serviced on August 18, 2011.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place? All UA's will be monitored daily M-F by the evening supervisor for returned results and proper documentation ongoing times 6 months with results to QA. MDS nurse will monitor return of elimination pattern upon admission, quarterly, and with a significant chance before completing MDs weekly times 4 weeks when working, monthly times 6 months with results to QA.	

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	appropriate toileting schedule for the resident. Interview with the Director of Nursing, on 07/22/11 at 11:00 A.M., indicated there was no patterning record located and no other assessment information for Resident #10. 3.1-41(a)(2)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure safe storage of chemicals for cleaning on 2 of 2 units. This had the potential to affect 10 of 58 residents on the Forest	F0323	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Rubbermaid disinfectant bucket has been moved inside the housekeeping	08/21/2011

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	Glen neighborhood and 6 of 58 residents on the Rosewood neighborhood. Findings include: During the environmental tour on 7/19/2011 at 1:14 p.m., a Rubbermaid container about 1/2 full of liquid was noted on top of the housekeeping cart close to Room 929. The cart was unattended and was not within sight of the housekeeper. The solution was identified by the Housekeeping Supervisor as 20 Neutral Cleaner and Disinfectant. There were no residents in the hallway at that time. During the environmental tour on 7/19/2011 at 1:34 p.m., a Rubbermaid container about 1/2 full of liquid was noted on top of the housekeeping cart close to Room 901. The cart was unattended and was not within sight of the housekeeper. The solution was identified by the Housekeeping Supervisor as 20 Neutral Cleaner and Disinfectant. There were no residents in the hallway at that time. During an interview on 7/19/2011 at 1:20 p.m., the Housekeeping Supervisor indicated the lid of the container should be kept locked and the cart kept in full view of the housekeeper at all times.		cart. The cart is to be locked at all times. The housekeeping cart policy has been updated to include the buckets be placed inside. The carts to be placed in front of the resident's door, and the cart should never be left unattended.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? In order to prevent this deficient practice from affecting other residents the bucket will be stored in the locked cart.3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not recur?The housekeeping supervisor is to monitor that all buckets be kept inside the cart. The housekeeping staff was in-serviced on July 27, 2011. The policy for housekeeping cars was updated on July 25, 2011.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place? The housekeeping supervisor will do a weekly audit for 4 weeks to ensure buckets are inside and the cart is kept within sight and then monthly for 6 months with results to QA.	

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	During an interview on 7/20/2011 at 11:55 a.m., the Assistant Director of Nursing indicated there were 58 residents residing on Forest Glen neighborhood of which 10 were confused and independently mobile; and 58 residents residing on the Rosewood neighborhood of which 6 were confused and independently mobile. A Material Safety Data Sheet dated 5/16/2011, and titled "20 Neutral Cleaner and Disinfectant" provided by the Housekeeping Supervisor on 7/19/2011 at 3:30 p.m., indicated the solution was irritating to the eyes and skin and could cause burns to the mouth if swallowed. A current policy, dated 2/1/1990 and revised 5/27/2010, and titled "Housekeeping Cart Use" indicated the cart was to be kept with the housekeeper at all times and the caddy with chemicals was never to be unattended. 3.1-45(a)(1)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure 1 resident (#41) of 8 residents reviewed for antipsychotic medication use had adequate indications for starting a new antipsychotic medications in a sample of 24. Also, the facility failed to attempt non-pharmacological measures before administering an as needed (PRN) psychotropic medication for 1 resident (#113) of 2 residents reviewed for PRN psychotropic medications in a sample of 24. Findings include:	F0329	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Care plan for #41 was revised to show interventions for agitation. Aggressive behaviors for #41 were documented to show need for Respirdol and an aggressive care plan was implemented. Physician clarified diagnosis for Respirdol. #113, nursing tries and documents interventions prior to giving Lorazepam. Documentation is provided on back of MAR.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	08/21/2011

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	1. Resident #41's clinical record was reviewed on 7/19/11 at 2:20 P.M. The record indicated the resident was admitted to the facility on 1/28/09 and had diagnoses including, but not limited to, dementia, history of previous elopement, depression, agitation. Review of the resident's physician's orders indicated on 7/8/11 he was started on Risperdal 0.5 milligrams (mg) for agitation and wandering. Review of the resident's multidisciplinary notes from 6/2/11 through 7/08/11 indicated on 6/11/11 at 5:00 P.M., the resident was propelling self in wheelchair in hall. On 6/23/11 at 10:00 P.M., the resident was propelling self in wheelchair up and down the hall most of the shift and enjoys banging the wheelchair into closed doors and entering others room and the resident was redirected several times. An interview with the Director of Nursing (DN) on 7/20/11 at 9:55 A.M., indicated the physician who ordered the Risperdal generally gets his information from the nurse's notes and summaries on behaviors from the Social Service Director. An interview with the Social Service Director on 7/20/11 at 11:45 A.M., indicated the only behavior tracking the		action(s) will be taken? All residents with prn anti-psychotic medication were identified and the MAR was checked for appropriate intervention prior to administering the prn med. All residents with aggressive behaviors were identified and chart was audited for an aggression care plan with interventions. All residents on an anti-psychotic medication were audited for an appropriate diagnosis.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All residents with aggressive behaviors will be discussed at 9a stand up meeting. SS will contact MDS of aggressive behaviors and the behavior logs will be checked daily by SS when working. SS will implement an aggression care plan and nursing will notify physician of aggressive behavior. The MAR will be checked weekly by night shift charge nurse for appropriate documentation of interventions prior to giving meds along with checking order for appropriate diagnosis. Staff was in serviced on August 18, 2011.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place? SS will check all new anti-psychotic medication orders for appropriate diagnosis weekly times 6 months	

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	facility had for Resident #41 in the past four months was reports of wandering on 4/22/11, 4/23/11 and 4/24/11 with no documentation of any interventions. The Social Service Director indicated the resident had no health care plan for agitation. The Social Service Director did not indicate she had prepared a summary of the resident's behaviors prior to the physician starting the resident on Risperdal on 7/8/11. 2. Resident #113's record was reviewed 7/18/2011 at 11:00 a.m. Resident #113's diagnoses included but were not limited to dementia with behavioral disturbances, depression, and high blood pressure. A current physician's order, dated 7/2011, indicated Lorazepam (a medication for anxiety) 0.5 milligrams was ordered on 6/2/2011 to be given three times per day as needed. A review of the June 2011 Medication Administration Record indicated Lorazepam had been given without documentation of non-pharmacological intervention on 6/8, 11, 14, 16, 17, 20, 21, 23, 25, and 28/2011. A review of the July 2011 Medication Administration Record indicated Lorazepam had been given without documentation of non- pharmacological		with results to QA. SS will have nursing call physician if diagnosis is missing or inappropriate. The charge nurse on night shift will check the MAR weekly ongoing with results to QA times 6 months for appropriate interventions before administering prn med along with an appropriate diagnosis.	

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	intervention on 7/3/2011. A review of the Nurse's notes for the above dates did not reveal any non-pharmacological interventions prior to the administration of the Ativan. Review of a health care plan for anxiety, initiated on 12/03/10, indicated there were no non- pharmacological interventions. In an interview on 7/19/2011 at 11:20 a.m., LPN #2 indicated interventions completed prior to giving as needed medications were documented on the back of the Medication Administration Record or in the Nurse's Notes. In an interview on 7/20/2011 at 12:15 p.m., the Social Services Director indicated interventions were supposed to be attempted prior to giving as needed medications and would be documented on the Medication Administration Record or the Behavior Tracking Record if the interventions had been attempted prior to administration. A current policy, dated 2/9/00 and updated 6/2011, and titled "Anti-psychotic Drugs" indicated the physician should document an acceptable diagnosis for the use of psychotropic medications in the			

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	resident's medical record. The policy did not indicate non- pharmacological interventions were to be attempted prior to administration. 3.1-48(a)(4)			
F0385 SS=D	A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. Based on record review and interview, the facility failed to ensure the physician for 1 of 7 residents reviewed with infections in a sample of 24 provided care timely when treatment orders were needed. (Resident #24) Finding includes: 1. During the initial tour of the facility, conducted on 07/18/11 between 10:30 A.M. - 11:30 A.M., the Director of Nursing indicated Resident #24 had a pressure ulcer on her left heel.	F0385	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?No corrective action for Resident #24, she is deceased.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents with BLE edema were assessed for redness and warmth and a need for physician notification. 3. What measures will be put into place or what systemic changes will be made to	08/21/2011

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	The clinical record for Resident #24 was reviewed on 07/19/11 at 10:50 A.M. The resident was admitted to the facility on 01/12/05 with diagnoses, including but not limited to diabetes and peripheral vascular disease. Review of a nurses note, dated 06/15/11 at 6:35 A.M., indicated the following: "...noted BLE (bilateral lower extremities) to be red et (and) warm to touch denies pain when asked. has BLE edema 3 + pitting even with legs being elevated throughout the night. Oncoming nurse updated et states she will call the MD (medical doctor) with update." A subsequent nurse's note, dated 06/15/11 at 1500 (3:00 P.M.), indicated the following: "res legs cont (continues) to be bright red in color et warm to the touch. (Physician's name)'s office notified. (Physician's name) out of office today. May call tomorrow to see if (physician's name) has any new orders." A nurse's note, dated 06/16/11 at 12:35 P.M., indicated the physician was updated. There was no physician's order given regarding Resident #24's legs. There was no further note or assessment of the resident's legs in the progress notes		ensure that the deficient practice does not recur?Policy, Notification Chane of Status, was revised and an all staff in-service was conducted on August 18, 2011. Staff was instructed to notify physician timely as stated in revised policy. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place? M-F, the DON will read nurses notes and 24 hour report sheet, checking for BLE edema and ensure physician was notified when there is redness and warmth ensuring orders are in place. This will be ongoing times 6 months with results to QA.	

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	until 06/19/11 at 11:00 A.M., which indicated the resident's legs were still swollen, red and warm to touch with 3+ pitting edema. The on-call physician was notified. A follow up nursing progress note, dated 06/19/11 at 12:00 noon, indicated the on call physician did not want to give any orders regarding Resident #24's legs but preferred the resident's regular physician to give orders the following day or see the resident in his office. A nursing progress note, dated 06/20/11 at 1830 (7:30 P.M.), indicated an order, written by Resident #24's attending physician, had been received for the antibiotic, Keflex, to be given for 7 days to treat the resident's cellulitis in her lower extremities. This was five days after the facility had made the initial call to inform the MD of the resident's condition. On 7/22/11 at 11:00 A.M., in interview with the Director of Nursing regarding the delay in obtaining initial treatment for the resident's cellulitis indicated there was no reason for the delay and lack of nursing follow up with the physician. 3.1-22(b)(1) 3.1-22(b)(2)			

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F0406 SS=D	If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. Based on observation, record review and interview, the facility failed to ensure recommendations and services outlined in the Annual Resident Review Assessment were followed for 1 of 1 residents with a diagnosis of mental retardation in a sample of 24. (Resident #1) Finding includes: 1. During the initial tour of the facility, conducted on 07/18/11 between 10:30 A.M. - 11:30 A.M., the Director of Nursing indicated Resident #1 was alert and oriented but was mentally retarded, was transferred with a mechanical lift, required moderate to maximum assistance with activities of daily living, was pushed in her wheelchair by staff, and was checked every two hours for incontinence and changed.	F0406	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 will have documentation to show that she is unable to participate in community integration programs. She will have POA representation established and documentation shows that she is unable to participate in self-care skills.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? When MMR residents are admitted, Identify IDEC report and follow through with any special recommendations that they recommend. Only 1 other MMR resides in building with no IDEC recommendations at this time.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does	08/21/2011

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	Resident #1 was observed on 07/20/11 at 2:00 P.M., and on 07/21/11 at 9:30 A.M., seated in her wheelchair in the main dining room participating in the activities program offered by the facility. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. The resident was admitted to the facility on 11/26/03 with diagnoses, including but not limited to personality disorder, seizure disorder, and mild mental retardation. The most recent Annual Resident Review Assessment located on the clinical record was dated October 2004. During the daily exit conference, conducted on 07/21/11 at 3:30 P.M., the Administrator was asked to provide any documentation regarding any needs related to Resident #1's diagnosis of mental retardation. On 07/22/11 at 9:15 A.M., the Social Services Director provided an Annual Resident Review Assessment (IDEC), completed on 12/02/10 for Resident #1. Review of the IDEC assessment recommendations indicated they included the following: "...4. (Resident's name) benefits from ongoing training and support to encourage her work on develop or minimally maintain any self-care skills (sic),		not recur? SS will provide more documentation with what IDEC recommends and implement care plans. SS will follow up with IDEC recommendations upon receiving and if not received within 90 days, SS will call and follow up.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place? SS coordinator will track all MMR residents and any IDEC reports to be updated and ensure report is on the chart monthly times 6 months with results to QA.	

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	5. (Resident's name) needs to be involved in a community integration program for cognitive and social stimulation and to continue to build/maintain her social skills., 6. (Resident's name) may benefit from continued utilization of OBRA specialized services for community integration...8. (Resident's name) may benefit from formal advocacy, health care representation, to advocate for her when her health declines...." Interview with the Administrator, on 07/22/11 at 10:00 A.M., indicated because the facility only housed two residents with developmental delays, they were not required to have notes made quarterly by a QMRP (Qualified Mental Retardation Professional). Review of the health care plans for Resident #1, current until 08/11, indicated there was no plan regarding assisting the resident with legal representation, no specific activities of daily living skill addressed to improve self skills, there was no plan for outside OBRA services for Resident #1, and no activity care plan intervention directed towards providing community integration activities to improve Resident #1's social skills. Interview with the Social Services Director, on 07/22/11 at 9:15 A.M.,			

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	indicated she had just received the 12/2010 IDEC assessment and was not aware she needed to address the recommendations made on the report. She indicated she had not attempted to obtain legal representation or contact the local OBRA center regarding possible services available for Resident #1. 3.1-23(a)(1)			
F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to ensure medications were available for administration as the physician had ordered for 2 of 24 residents reviewed for medication	F0425	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No action needed for Residents #69 and #107.	08/21/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	availability in a sample of 24. (Resident #69, Resident #107) Findings include: 1. Resident #69's record was reviewed 7/19/20211 at 3:45 p.m. Resident #69's diagnoses included but were not limited to diabetes, congestive failure, and pulmonary edema. A current physician's order, dated 7/15/2011, indicated Scopolamine (a medication for pain) had been ordered 5/13/2011 to be administered 0.25 milligrams every 8 hours through a patch and Neurontin (a medication for pain) 100 milligrams three times per day had been ordered 7/12/2011. A review of the Medication Administration Record (MAR), dated 7/2011, revealed initials of the nurse administering Scopolamine were circled on 7/16 at 8 p.m.; and 7/17/2011 at 8 a.m., noon, and 8 p.m. On the back of the MAR, under the date 7/16/2011, the record indicated Scopolamine was not given as there was no supply on hand. A review of the Medication Administration Record (MAR), dated 7/2011, revealed initials of the nurse administering Neurontin were circled on		Medications were already received and administered at the time of the survey.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?Medication error report must be completed within 24 hours and turned into DON/ADON for any medication that is considered unavailable. All nurses were in serviced on August 18, 2011 to follow existing policy to reorder meds when only a 4 day supply remains and follow Order and Receipt of Drugs from Pharmacy Policy. All MAR were reviewed for missed medications by night shift charge nurse.3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not recur? Staff will be in serviced on obtaining medications when they are not available in facility. Revised policy reviewed at in-service on August 18, 2011.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place? Night shift charge nurse will look at MAR weekly to ensure nurses are following policy and report to DON any discrepancies found ongoing with results to QA times 6 months.	

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	155747	A. BUILDING 00 B. WING	07/22/2011

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	7/14- 8 p.m. dose; 7/15- noon and 8 p.m. dose; 7/16- noon and 8 p.m. doses; 7/17- 8 am, noon and 8 p.m. doses; and 7/18- 8 a.m. and noon doses. On the back of the MAR, under the date 7/14 and 7/15/2011, the record indicated medications were not given as there was no supply on hand and the facility was awaiting family and hospice to supply the medication. In an interview on 7/21/2011, LPN #1 indicated although the family and hospice had been notified, the medication did not arrive until 7/18/2011. 2. Resident #107's record was reviewed 7/20/2011 at 2:45 p.m. Resident #107's diagnoses included but were not limited to end stage heart disease, congestive heart failure and depression. A current physician's order, dated 5/31/2011, indicated Humulin N 30 units BID had been ordered 5/1/2011. A physician's order, dated 6/20/2011, indicated to use Novolin N in place of Humulin N. A review of the Medication Administration Record (MAR), dated 6/2011, revealed initials of the nurse administering insulin on 6/20/2011 at 8:00 a.m. were circled. On the back of the			

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	MAR, under the date and time 6/20/2011 at 8:00 a.m., the record indicated Novolin N 30 units was not given as there was no Novolin N on hand. A review of the Medication Administration Record (MAR), dated 7/2011, revealed initials of the nurse administering insulin on 7/8/2011 at 8:00 a.m. were circled. On the back of the MAR, under the date and time 7/8/2011 at 8:00 a.m., the record indicated Novolin N 30 units was not given as there was no Novolin N in stock. A document provided by the Administrator on 7/20/2011 at 10:00 a.m., indicated the pharmacy had been notified of the need for Humulin N on 6/17/2011. The pharmacy stocked Novolin N, and was willing to substitute, but did not communicate with the facility until 6/20/2011, causing a missed dose. Additionally, on 7/8/2011, the facility had not ordered the insulin causing a missed dose. In an interview 7/19/2011 at 5:30 p.m., LPN #2 indicated medications were available from the hospital pharmacy whenever they were needed. A current policy dated 2/1/94 and updated 2/9/00 titled Unit Dose Dispensing			

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	System indicated the pharmacy's on call number should be utilized to obtain medications before the next scheduled delivery and when the medication is not available in the emergency box. 3.1-25(a)			
F0505 SS=D	The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to notify the physician of an abnormal lab urinalysis (UA) result for 2 of 24 residents (#10 and #33) reviewed for lab results in a sample of 24. Findings include: 1. Resident #33's clinical record was reviewed on 7/19/11 at 3:50 P.M. The record indicated on 6/21/11 a physician's order was received to start treatment with Levaquin for 7 days for an urinary tract infection (UTI) and to obtain a follow-up UA once the Levaquin course was completed. On 7/1/11, a physician's order was received for a culture of urine if white blood count (WBC) greater than 5.	F0505	1. What corrective action(s) will be accomplished for those residents found to have bee affected by the deficient practice? Lab results were WNL, faxed to physician with no further orders received for resident #10 . Lab results were placed on chart for resident #33 and physician notified of results.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?Every resident chart was reviewed for outstanding lab orders on 8/5/11.3. What measures will be put into place or what systemic changes will be make to ensure that he deficient practice does not recur?A lab tracking flow sheet was developed and has been implemented to track labs	08/21/2011

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	On 6/30/11, a UA was obtained that indicated the WBC 25-50. A culture of the urine was not completed. The UA lab result of 6/30/11 was not available in the resident's record in the facility. On 7/20/11 at 9:46 A.M., the lab faxed the UA results to the facility and the facility then faxed the UA results to the physician at an unspecified time on 7/20/11. An interview with the Director of Nursing (DN) on 7/20/11 at 9:45 A.M., indicated the UA lab results should have been in the chart after completion and the physician should have been notified of the lab results. 2. The clinical record for Resident #10 was reviewed on 07/20/11 at 11:40 A.M. A physician's order was received on 06/21/11 for a urinalysis to be done with a culture and sensitivity test if there were equal to/or more than 5 white blood cells in the resident's urinalysis test. Review of the urinalysis test results, completed on 06/22/11, indicated there were 10 - 15 white blood cells in the resident's urine. However, there were no culture and sensitivity results noted in the resident's clinical record. The urinalysis results were not received by the facility until 07/13/11. A culture and sensitivity test result was provided, on 07/22/11,		ordered, received and physician notification. In-service held for nursing staff on obtaining lab results, placing on chart and physician notification.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place. Evening supervisor will monitor lab results for timely return, physician notification, and chart placement daily when working ongoing with results to QA times 6 months.	

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	dated as completed on 06/23/11, which indicated there was a "growth of contaminants." There was no indication the facility was aware of the contaminated specimen and no indication the physician had been contacted timely to ensure a retest was not desired by the physician. Interview with the Director of Nursing, on 07/22/11 at 11:00 A.M., indicated the resident's physician had not been made aware the culture and sensitivity had not been done by the laboratory. 3.1-49(f)(2)			
F0507 SS=D	The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. Based on interview and record review, the facility failed to ensure laboratory results were available on the chart for 3 of 24 residents reviewed for lab results on the chart in a sample of 24. (Resident #84, 10, 33)	F0507	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? #10-7/22/11, Physician was notified of results with no further orders received. #33, Physician was notified of results with no further orders received.	08/21/2011

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	Findings include: 1. Resident #84's record was reviewed 7/21/2011 at 10:40 a.m. Resident # 84 's diagnoses included but were not limited to dementia, high blood pressure, and osteoporosis. A current physician's order summary indicated BMP and CBC were to be drawn yearly. A review of laboratory results revealed BMP and CBC results for 6/2/2010, but no results were on the current chart after that time. In an interview on 7/21/2011 at 11:00 a.m., the Assistant Director of Nursing indicated the labs had been drawn, but the results were not on the chart. She further indicated the lab was faxing the results so they could be placed on the chart. On 7/21//2011 at 1:45 p.m., the Assistant Director of Nursing provided the lab results for the BMP and CBC obtained 4/2/2011. The results were within normal limits. 2. The clinical record for Resident #10 was reviewed on 07/20/11 at 11:40 A.M. A physician's order was received on 06/21/11 for a urinalysis to be done with a culture and sensitivity test if there were		#84, Lab results were WNL, faxed to physician with no further orders received.2. How other residents having potential to be affected by he same deficient practice will be identified and what corrective actions(s) will be taken? Every residents' chart was reviewed for outstanding and current lab orders on 8/15/11 by evening supervisor.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A lab tracking flow sheet was developed and has been implemented to track labs ordered, received, and physician' s orders received. Staff was in-service on August 18, 2011.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place?Evening supervisor will monitor lab results for timely return, physician notification, and chart placement daily when working ongoing with results to QA times 6 months.	

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	equal to/or more than 5 white blood cells in the resident's urinalysis test. Review of the urinalysis test results, completed on 06/22/11, indicated there were 10 - 15 white blood cells in the resident's urine. However, there were no culture and sensitivity results noted in the resident's clinical record. The urinalysis results were not received by the facility until 07/13/11. A culture and sensitivity test result was provided, on 07/22/11, dated as completed on 06/23/11, which indicated there was a "growth of contaminants." 3. Resident #33's clinical record was reviewed on 7/19/11 at 3:50 P.M. The record indicated on 6/21/11 a physician's order was received to start treatment with Levaquin for 7 days for an urinary tract infection (UTI) and to obtain a follow-up UA once the Levaquin course was completed. On 7/1/11, a physician's order was received for a culture of the urine if the white blood count (WBC) was greater than 5. On 6/30/11, a UA was obtained which indicated the WBC 25-50. A culture of the urine was not completed. The UA lab result of 6/30/11 was not available in the resident's record in the facility. On			

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	7/20/11 at 9:46 A.M., the lab faxed the UA results to the facility and the facility then faxed the UA results to the physician at an unspecified time on 7/20/11. An interview with the Director of Nursing (DN) on 7/20/11 at 9:45 A.M., indicated the UA lab results should have been in the chart after completion. 3.1-49(f)(4)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure physician's orders	F0514	1. What corrective action(s) will be accomplished for those residents found to have been	08/21/2011

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	were correctly transcribed or clarified in the clinical record for 2 of 24 residents (Residents #34 and #1) in a sample of 24. Findings include: 1. Resident #34's clinical record was reviewed on 7/18/11 at 2:50 P.M. The record indicated the resident was readmitted to the facility from an acute care setting on 5/10/11. On the physician's orders on readmission on 5/10/11 medication orders were received to discontinue Lantus (insulin) 20 units at bedtime (hs). On 5/24/11, the resident's monthly physician orders indicated Lantus 20 units to be given at bedtime. On the monthly physician's orders from 6/28/11 indicated Lantus 20 units to be given at bedtime. On the physician's orders on readmission to the facility on 5/10/11, the resident was to have Accuchecks (finger stick blood sugar monitoring) for blood sugars before each meal and at bedtime with insulin coverage with Novolog on a sliding scale. On the monthly physician's orders of 5/24/11 and on 6/28/11, Accuchecks were to be completed before meals and bedtime with insulin coverage before meals with no sliding scale insulin coverage at bedtime.		affected by the deficient practice? For resident #34, resident was receiving correct insulin coverage, but previous order was on MAR. Physician notified for clarification. Resident #1, stop date was on MAR, but not on order. Physician called for stop date after 7 days (clarification) Antibiotic has been stopped.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?For all residents on insulin, the MAR was checked against order for accuracy. For all residents on antibiotics, the order was checked for stop date along with the MAR.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Staff was in serviced on August 18, 2011 to obtain stop date with order and document. Night shift charge nurse will recheck admitting orders against MAR within 24 hours of an admission. Charge nurse will notify physician if a clarification is needed.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place?Restorative nurse will check orders M-F for stop date and have charge nurse obtain if missing ongoing times 6 months with results to QA. The	

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	Review of the resident's Medication Administration Records (MARs) from readmission on 5/10/11 to the present indicated the resident was receiving the medications as ordered by the physician on 5/10/11 of no routine Lantus 20 units at bedtime and the resident was receiving insulin coverage on a sliding scale at bedtime. An interview with the Director of Nursing (DN) on 7/19/11 at 1:00 P.M., indicated the resident was getting the correct dosages of insulin despite incorrect physician's orders on the monthly rewrites. 2. The clinical record for Resident #1 was reviewed on 07/20/11 at 2:30 P.M. A physician's order, dated 05/05/11, indicated the resident was to receive the antibiotic, Flagyl 500 mg, three times a day, due to loose stools. There was no time frame given for how long the antibiotic was to be given. Review of the medication administration record for May 2011 indicated the Flagyl was given for 7 days and then was discontinued. The physician was not notified of the need to clarify the antibiotic order to include the length of treatment desired. Interview with the Director of Nursing, on 07/22/11 at 11:00 A.M., indicated there		night shift supervisor will check admitting orders against MAR within 24 hours of an admission, ongoing times 6 months with results to QA.	

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	was no clarification made and no additional information available regarding the lack of a stop date for the Flagyl for Resident #1. 3.1-50(a)(2)			
F9999	STATE FINDINGS 3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously	F9999	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Physical for employee #12 has been signed by the physician.2. How other residents having the potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken? Infection Preventionist #2 will check all Woodcrest employee files to ensure the physician signature is present on all physicals. If signature is missing she will follow up with Corporate Medicine.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does	08/21/2011

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	positive reaction can be documented. the result shall be recorded in millimeters of induraiton with the date given, date read, and by whom administered. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 personnel files reviewed contained a signed physical examination completed for 1 of 5 employees reviewed. (Employee #10) Finding includes: During the review of personnel files, completed on 07/21/11 with Employee #12, the personnel file for Employee #10, hired on 03/11/11, indicated the physical examination was not signed by the physician. Handwritten on the form was "previous physical 07/16/10. no changes" but there was no physicians signature on the form. Interview with Employee #12 confirmed the physician or nurse practitioner completing the physical had not signed the physical examination form. 3.1-14(t)		not recur?IP #2 will check for presence of physician signature on the physical prior to filing. A form will be developed for tracking.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance programs will be put into place? IP, #1, will audit 5 physicals per month to ensure signature is on document. This will be done monthly times 6 months with results to QA.	

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